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Examining the Relation Between Discrimination and Suicide Among Black Americans: The Role of Social Pain Minimization and Decreased Bodily Trust

Shruti S. Kinkel-Ram, Jonathan Kunstman, Jeffrey M. Hunger, and April Smith
Department of Psychology, Miami University

Despite robust associations between discrimination and suicidality, the mechanisms underlying this relationship are poorly understood (Gomez et al., *Journal of Youth and Adolescence*, 2011, *40*, 1465; Hunger et al., *Stigma and Health*, 2020a, *5*, 217). The current study tested whether discrimination leads to suicidal ideation through a process whereby social pain minimization erodes trust in bodily sensations. We predicted that among Black participants, discriminatory experiences would be related to social pain minimization and this invalidation in turn was predicted to relate to impaired trust in bodily sensation and ultimately, suicidal ideation. Given the systemic racism Black Americans experience, we recruited 341 Black participants and asked them to complete surveys assessing their experiences of discrimination, social pain minimization, bodily trust, and suicidal ideation. Findings supported the proposed model, and were consistent with the hypothesis that discrimination was related to suicidal ideation through minimization of social pain and reduced trust of body sensations. These findings suggest that clinical interventions targeting bodily trust and public health policy initiatives targeting social pain minimization may be useful methods of decreasing suicidal ideation in those that face discriminatory experiences.

Keywords: suicide, discrimination, interoceptive awareness

The relationship between discrimination and suicidality is well-documented. For example, perceived discrimination is associated with higher odds of suicide attempts across different ethno-racial groups (Gomez et al., 2011). The chronic experience of discrimination among Latinx individuals is associated with greater suicidal ideation (Kwon & Hon, 2019). Perceived discrimination is associated with increased suicidal ideation and attempts by Asian-Americans (Cheng et al., 2010; Li et al., 2018). Among Black Americans, experiences of racial discrimination are associated directly with increased suicidal ideation (Walker et al., 2014). Black Americans who experience racial discrimination themselves, as well as have mothers who experience racial discrimination, are more likely to have suicidal thoughts, make suicide plans, and attempt suicide (Arshanapally et al., 2018).

In addition to race-based discrimination, weight-based discrimination is associated with increased suicidal ideation (Hunger et al., 2020a). Additionally, discrimination experienced by sexual and gender minority individuals is associated with a history of suicide attempts and non-suicidal self-injury (Busby et al., 2020; Clements-Nolle et al., 2006). Moreover, individuals with intersectional stigmatized identities can experience additional discrimination. For example, racial and ethnic minority individuals in the LGBTQ+ community in particular experience increased suicide attempts compared to their White counterparts (O'Donnell et al., 2011). Thus, across a variety of socially stigmatized groups, discrimination is robustly associated with suicidality.

Despite this growing body of research linking discrimination and suicidality, the mechanisms underlying this relationship are not well understood. In this article we propose a theoretical model and provide preliminary cross-sectional evidence that experiencing discrimination increases social pain minimization, which disrupts interoception and ultimately increases suicidal ideation (see Figure 1). Social pain minimization refers to the feeling that others devalue and dismiss negative affect and psychological distress following negative social experiences (e.g., unfairness, disrespect, exclusion; Benbow et al., under review). Interoception was operationalized as trust in bodily sensations (Mehling et al., 2012). The present model proposes that discrimination leads to suicidal ideation through a process whereby social pain minimization erodes trust in bodily sensations. This diminished bodily trust then leads individuals to be at risk for a host of negative mental health outcomes, including suicidal ideation.

Discrimination, Social Pain Minimization, and Mental Health

Members of stigmatized groups routinely experience discrimination and unfair treatment (Uhlmann et al., 2010). Over time, these negative social experiences accumulate wear on both mind and body (e.g., Jackson et al., 2006; Pascoe & Smart Richman, 2009; Schmitt et al., 2014; Williams & Mohammed, 2009). We refer to the negative emotions and psychological distress caused by these hurtful social experiences as social pain. In addition to the direct negative relationship between discrimination and health, there

Shruti S. Kinkel-Ram https://orcid.org/0000-0003-0637-2510

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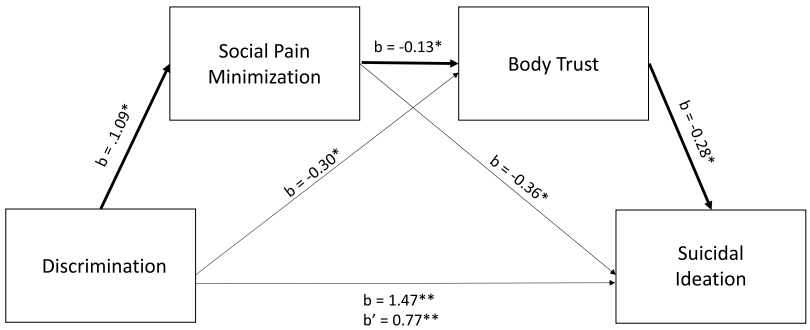
Correspondence concerning this article should be addressed to April Smith, Department of Psychology, Miami University, 90 Patterson Avenue, Oxford, OH 45056, United States. Email: aprilsmith@miamioh.edu

Figure 1

Serial Mediation Depicting the Relation Between Discrimination and Suicidal Ideation Through Social Pain Minimization and Lack of Body Trust



is also reason to believe that discrimination negatively impacts mental health because it sets the stage for perceived social pain minimization.

In the current work, we operationalized social pain minimization as the perception that listeners devalue and dismiss speakers' experiences with social pain. For instance, individuals experience social pain minimization when they feel others are apathetic to their pain after being excluded by friends, disrespected by coworkers, or the loss of romantic partners. When individuals feel that listeners devalue or invalidate their hurt when they share negative social experiences, social pain minimization occurs.

Several lines of research converge to suggest that Black individuals may be particularly likely to experience social pain minimization and that pain minimization may negatively impact mental health. First, Black individuals are frequently dehumanized and denied both complex emotions and emotional capacities (e.g., Albarello & Rubini, 2012; Cuddy et al., 2007; Goff et al., 2008). For example, Cuddy et al. (2007) found that Black survivors of Hurricane Katrina had their capacities to feel pain and grief minimized and these dehumanizing judgments undermined intentions to help hurricane survivors. From this perspective, Black individuals may experience social pain minimization because others dehumanize their emotional capacities and provide insufficient social support during times of crisis.

Second, research on microinvalidations provides evidence that Black individuals regularly feel their affective responses to race-based incivility, disrespect, and discrimination are devalued (e.g., Nadal et al., 2011; Sue et al., 2007; West, 2019). With time, repeated experiences with microinvalidations can lead individuals to question their emotions, heighten negative affect, and increase depressive and somatic symptoms (Huynh et al., 2012; Nadal et al., 2014; Sue, 2010). As this research illustrates, not only do Black individuals feel their emotions are invalidated following race-related mistreatment, this experience of race-related pain minimization negatively impacts trust in inner affective states and broader mental health. For Black Americans who experience social pain minimization, interoception, and ultimately mental health may suffer.

Third, evidence that Black individuals may feel their social pain is minimized comes from work on third-party judgments of social pain (Deska, Kunstman, Bernstein, et al., 2020; Deska, Kunstman, Lloyd, et al., 2020). As a growing body of research attests, people regularly believe that Black people feel less pain than White people (e.g., Deska, Kunstman, Bernstein, et al., 2020; Trawalter et al., 2012). Whether judging the physical pain caused by broken bones or the social pain caused by ostracism and disrespect, people often expect Black individuals will feel less pain than White individuals. Moreover, research has connected these racial biases in social pain to racialized beliefs about toughness and finds these biases further impair judgments of coping needs (e.g., Deska, Kunstman, Bernstein, et al., 2020; Hoffman & Trawalter, 2016). People believe that greater life hardship has made Black individuals tougher and less sensitive to pain than White individuals. Consequently, they expect Black individuals need less social support to cope with distress than White individuals. Here it is worth noting, these biases in pain judgments often extend to Black participants (Deska, Kunstman, Bernstein, et al., 2020; Trawalter et al., 2012), suggesting that ingroup members may also minimize Black individuals' social pain. Black individuals may be particularly likely to feel their pain is minimized because both ingroup and outgroup members show racial biases in social pain.

Consistent with the above theorizing, recent research finds that racial biases in third-party social pain judgments extend to first-person experiences with social pain minimization. Black individuals feel their social pain is minimized more than White individuals (Benbow et al., under review). Moreover, perceived social pain minimization was associated with more frequent daily experiences with social mistreatment and worse mental health (Benbow et al., under review). The more people experienced every day mistreatment, the more they felt others minimized their social pain. Moreover, perceived social pain minimization was not only related to greater stress and worse mental health, but also mediated race's effect on these markers of well-being. Black individuals felt their pain was minimized more than White individuals and minimization was associated with worse mental health.

Social Pain and Interoception

Black Americans often have their experiences with social pain, including race-based mistreatment, minimized and minimization has been linked to worse mental health (Benbow et al., under review; Huynh et al., 2012; Nadal et al., 2014). We theorize that another consequence of having distress and negative emotional responses invalidated may be deficits in interoceptive awareness, or a disconnect from one's internal sensations. Interoceptive

awareness is the extent to which one feels connected to and can accurately perceive their own physical bodily sensations, such as heart rate, respiration, touch, satiety, pain, and emotions (Smith, Dodd, et al., 2020). Deficits in interoceptive awareness can lead one to become unaware of or disconnected from internal sensations, or to misinterpret these sensations.

Although research explicitly examining the relationship between social pain minimization and interoceptive awareness does not exist to date, studies on experiences of invalidation of pain perception provide some evidence for this relationship. Following operant conditioning models, if a person does not receive any positive reinforcement in the form of social support when disclosing their pain, they may be less likely to disclose this pain in the future and may even suppress pain (Edmond & Keefe, 2015). Moreover, invalidation has been associated with emotion dysregulation and disrupted sensitivity and appraisal of emotions (Crystal, 2018; DeShong et al., 2019). Further, parental invalidation has been associated with decreased awareness of emotions in their children (Lambie & Lindberg, 2016). Thus, invalidating experiences, like social pain minimization, can lead to emotion suppression and emotion dysregulation, both of which are related to worse interoception (Price et al., 2019; Seth, 2013; Willem et al., 2019). This research suggests that repeated experiences with social pain minimization could lead Black individuals to question the validity of their internal experiences, ultimately resulting in interoceptive deficits. In turn, these interoceptive deficits may leave individuals feeling disconnected from their bodies, putting them at heightened risk for lethal self-injury.

Interoception and Suicidality

Interoceptive awareness is a multi-faceted construct. For instance, a commonly used measure of interoceptive awareness, the Multidimensional Assessment of Interoceptive Awareness (MAIA), includes the following subscales: noticing, not-distracting, not-worrying, attention regulation, emotional awareness, self-regulation, body listening, and body trust (Mehling et al., 2012). Individuals with suicidal ideation exhibit lower levels of interoceptive awareness than individuals without suicidal ideation across most facets of interoception (Forrest et al., 2015; Rogers et al., 2018). Deficits in interoceptive awareness are associated with increased suicidal thoughts (Rogers et al., 2018; Smith, Dodd, et al., 2020). Suicidal ideation, specifically thoughts of killing oneself has been found to link suicidality and other forms of psychopathology, such as eating disorders (Smith, Forrest, et al., 2020). Individuals with suicidal ideation are also less likely to perceive their bodily sensations as useful and subsequently less likely to attend and respond to their bodily sensations (Forkmann et al., 2019). Further, interoceptive deficits are related to various features of suicidality, such as frequency of suicide attempts and lethality of attempts (Duffy et al., under review; Smith, Dodd, et al., 2020). Individuals who have attempted suicide are more likely to experience interoceptive "numbing" and are less aware or responsive to painful sensations (DeVille et al., 2020). Hence, while thoughts about killing oneself may be troubling for someone without suicidal ideation, individuals who had poor interoceptive awareness may not view these thoughts as troubling as they do not view themselves or their bodies to be something worth protecting (Forrest et al., 2015; Smith, Forrest, et al., 2020). Moreover, individuals who attend to or address distress signals sent from the body may be unable to regulate this distress, leading to emotion dysregulation and suicidal thoughts (Forkmann et al., 2019).

Moreover, the body trust facet of interoceptive awareness in particular has robust associations with suicidal ideation and attempts (Rogers et al., 2018). The body trust facet of interoceptive awareness is the extent to which one perceives their body to be trustworthy, and their bodily sensations as dependable and useful for making decisions (Duffy et al., 2018). Relative to the other aspects of interoceptive awareness, this facet has the most consistent associations with increased lifetime suicidal thoughts and behaviors, and moderates the relationship between other risk factors, such as disordered eating behaviors, and suicidality (Duffy et al., 2018; Rogers et al., 2018). Low bodily trust is believed to facilitate self-injury as it allows for the body to be seen as untrustworthy, undependable—essentially "other." In effect, and in keeping with ideation-to-action theories of suicide (Klonsky & May, 2015; Van Orden et al., 2010), individuals with interoceptive deficits are missing a crucial barrier to disengage from self-injury, that of understanding and caring for the body.

Discrimination and Interoceptive Deficits

Studies testing the relationship between discrimination and suicidal ideation have not yet explored the relationship between these variables and interoceptive deficits. However, there is reason to believe that a link between discrimination and interoceptive deficits may exist beyond the influence of social pain minimization. For example, the dehumanizing and invalidating nature of discrimination may lead individuals to question their own internal experiences, eroding the interception of trust and bodily cues. Moreover, interoceptive deficits have been observed in higher weight individuals (Duffy et al., 2020; Koch & Pollatos, 2014), which may be due in part to this population both experiencing and anticipating weight discrimination from others (Hunger et al., 2020b).

Current Study

The current work integrates social psychological research on racial biases in social pain judgments with clinical theories of suicide to provide an interdisciplinary test of the hypothesis that discrimination increases suicidal ideation by increasing social pain minimization and decreasing bodily trust. We predicted that among Black participants, discrimination would lead people to feel their pain was devalued and minimized, impairing trust in bodily sensation and ultimately increasing suicidal ideation. To test this hypothesis, we conducted a cross-sectional serial mediation model in which discrimination leads to suicidal ideation through a process whereby social pain minimization erodes trust in bodily sensations. We hypothesize that this diminished bodily trust increases risk for a host of negative mental health outcomes, including suicidal ideation.

Method

Participants

Given the historical and contemporary experiences with discrimination faced by Black Americans, we sought to recruit Black participants to provide an initial test of our model. Participants that indicated that they identified as Black individuals above the age

of 18 on Qualtrics Participant Panels were recruited via email and compensated for their time. Participants' demographic variables were confirmed using the questionnaire included in the study. However, participants did not know that their race was the inclusion criteria for study participation. This study was approved by the Miami University Institutional Review Board and informed consent for all participants was obtained at the beginning of the study. After screening out participants who failed attention checks, we were left with a sample size of 341. After removing participants with missing data, our final sample size was 320. Participants were 76.2% female, $M_{age} = 36.56$ ($SD = 14.55$). Please refer to Table 1 for more details on the sample's demographic information. In our sample, 20.3% ($n = 65$) of the sample indicated that they had a clinically significant suicidal ideation (Michaels et al., 2015).

Measures

Discrimination

Participants' experiences with discrimination were assessed using the 9-item Everyday Discrimination Scale (Williams et al., 1997). This scale asks, *In your day-to-day life, how often do any of the following things happen to you?* followed by a series of situations such as, *You are treated with less respect that other people* and, *You receive poorer service than other people at restaurants or stores*. Participants rated the frequency of these experiences on a scale from 1 (*never*) to 4 (*almost every day*). In the current study, the internal consistency of this measure was good ($\alpha = .89$).

Social Pain Minimization

Participants' feelings of social pain minimization were measured with an eight-item measure (e.g., *When I tell others about times I've been treated unfairly, I feel people underestimate my hurt*; Benbow et al., under review). Participants expressed (dis)agreement on a 1 (*strongly disagree*) to 7 (*strongly agree*) Likert scale. The full measure with all items can be found in Appendix. This measure has been found to exhibit discriminant validity and excellent reliability (Benbow et al., under review), and in the current study, the internal consistency of this measure was excellent ($\alpha = .94$).

Table 1
Participant Demographic Information

Characteristic	*N*	%
Sample size	320	100
Gender		
Female	243	75.9
Male	76	23.8
Non-binary	1	.3
Gender identity		
Cisgender	311	97.2
Transgender	7	2.2
Not listed	2	.6
Race		
Black/African-American	320	100
Ethnicity		
Hispanic	9	2.8
Not Hispanic	309	96.6
Not listed	2	.6

Body Trust

Body trust was measured with the body trust subscale of the MAIA-2 (Mehling et al., 2018). This subscale is three items that are rated on a 0 (*never*) to 5 (*always*) scale (e.g., *I am at home in my body; I trust my body sensations*). In the current study, the internal consistency of this measure was good ($\alpha = .88$).

Suicidal Ideation

Suicidal ideation was assessed by the Depressive Symptom Inventory-Suicidality Subscale (DSI-SS; Joiner et al., 2002). The DSI-SS is a four-item self-report measure of the presence and severity of suicidal thoughts and impulses. Items are rated on a 0–3 scale such that greater scores indicate greater severity of suicidal ideation. Participants select the statement from each group that best reflects their experiences in the past 2 weeks. In the current study, the internal consistency of this measure was excellent ($\alpha = .93$).

Data-Analytic Plan

Data were examined for normality and completeness. Except for suicidal ideation, which was slightly skewed and kurtotic (skew = 2.3, kurtosis = 5.2), all other variables demonstrated acceptable levels of skew and kurtosis. Given the very low level of missing data on variables of interest (0.3%–1.6%), missing data were handled via listwise deletion. To test the current model, we used a moderated mediation analysis in PROCESS macro (model 6) with 10,000 bootstraps (Hayes, 2013).

Results

All study variables were significantly related with one another, see Table 2. The magnitude of the relationships between discriminatory experiences and body trust, social pain minimization and body trust, and body trust and suicidal ideation was small ($r_{range} = -.25$ to $-.26$). The magnitude of the relationships between discriminatory experiences and suicidal ideation, and social pain minimization and suicidal ideation was small-moderate ($r_{range} = .36$ to .37). Finally, the magnitude of the relationship between discriminatory experiences and social pain minimization was moderate ($r_{range} = .51$). In sum, the relationships between all the study variables were significant and indicated small to moderate effects in the current sample. To test the model, we used the PROCESS macro (model 6) with 10,000 bootstraps (Hayes, 2013). The indirect effect of the cross-sectional serial mediation was significant, as indicated by the fact the 95% confidence interval (CI) did not include zero, $b = 0.04$, 95% CI = [0.004, 0.10]. This finding is consistent with the hypothesis that discrimination was related to suicidal ideation through minimization of social pain and reduced trust of body sensations.

The analysis simultaneously tests two alternative single-mediation pathways, both of which were significant. Specifically, the effect of discrimination on suicidal ideation through social pain minimization was significant, $b = 0.40$, 95% CI = [0.15, 0.69]. Additionally, the effect of discrimination on suicidal ideation through lack of body trust was significant, $b = 0.08$, 95% CI = [0.005, 0.20], see Figure 1.

Table 2
Zero-Order Correlations for Discrimination, Bodily Trust, Suicidal Ideation, and Social Pain Minimization

Variable	1	2	3	4
Mean (*SD*)	2.08 (.69)	3.39 (1.24)	1.19 (2.46)	3.45 (1.53)
1. EDS	—			
2. BT	−.26**	—		
3. DSI	.36**	−.25**	—	
4. SPM	.51**	−.25**	.37**	—

Note. EDS = discrimination as measured by the everyday discrimination scale; BT = bodily trust as measured by MAIA; Eating = implicit associations with eating stimuli; DSI = suicidal ideation as measured by DSI; SPM = social pain minimization
* $p < .05$. ** $p < .01$.

Discussion

These findings provide initial, cross-sectional support for our proposed model. These findings suggest that among Black Americans in our sample, discriminatory experiences are positively associated with social pain minimization and decreased bodily trust, which ultimately is associated with increases in suicidal ideation. These findings support previous work suggesting that discrimination and social pain minimization lead to adverse mental health outcomes (Benbow et al., under review; Huynh et al., 2012; Sue, 2010). Our findings are also consistent with empirical theories of minority health disparities, such as minority stress theory (Meyer, 2003). The minority stress model posits that individuals with stigmatized identities are particularly susceptible to negative health outcomes due to stressors such as discriminatory experiences, expectations of social rejection and stigma, and internalization of negative societal attitudes toward their specific social identities (Meyer, 2003). These stressors not only contribute to mental health disparities such as increased substance use and depression, but physical health disparities such as increased risk for HIV, cardiovascular issues, and other chronic conditions (Hatzenbuehler et al., 2008; Lick et al., 2013). Our findings add to this literature by providing evidence that discriminatory experiences and social pain minimization are linked to increased suicidal ideation.

The current results also affirm the important role of psychological experiences in understanding the relationship between discrimination and mental health. Although research consistently connects discrimination and negative health outcomes (e.g., Bardol et al., 2020; Major et al., 2013; Paradies et al., 2015; Schmitt et al., 2014; Williams & Mohammed, 2009), this work predominantly focuses on the *frequency* with which individuals encounter discrimination. Research has dedicated far less attention to psychological (e.g., anticipated stigma) and interpersonal mechanisms (e.g., social pain minimization) that might help explain how discrimination gets "under the skin" to undermine health (Hatzenbuehler, 2009). In the current work, perceived social pain minimization was related to increased suicidal ideation. By including social pain minimization in the current model, these results illustrate that psychological experiences may be necessary to form a complete picture of the relationship between discrimination and mental health.

Additionally, our findings are congruent with the literature on interoception and suicidality, as past studies have found a relationship between interoceptive deficits and suicidal thoughts and behaviors (Rogers et al., 2018; Smith, Dodd, et al., 2020). In particular, the findings from this study replicate past research showing a notable association between the deficits in the bodily trust facet of interoceptive awareness and increased suicidality (Duffy et al., 2018; Rogers et al., 2018). Our findings demonstrate a relationship between diminished body trust and suicidality and extend these past findings by showing that diminished bodily trust facilitates suicidal ideation through other factors such as discriminatory experiences and social pain minimization. Additionally, this was the first study to replicate the link between bodily mistrust and suicidality in a minority sample. These findings provide further support for the theory that bodily mistrust, or seeing one's body as disconnected and untrustworthy, can facilitate increased suicidal thoughts and behaviors (Smith, Dodd, et al., 2020).

Clinical and Public Health Implications

The findings of the current study demonstrate that discriminatory experiences are both directly and indirectly associated with increased suicidality. In order to aid suicide prevention and treatment efforts, systematic discrimination of stigmatized identities needs to be addressed at not only the individual level, but also the societal level through public policy. As Stuart (2005) eloquently stated—"fighting stigma and discrimination is fighting for mental health." For instance, social policies may directly and indirectly contribute to mental health disparities in the LGBTQ+ community through decreased access to health promotion and social support resources, which compounds the stress caused by stigma and discrimination, as outlined by minority stress theory (Hatzenbuehler, 2010). Minority stress can occur at the distal level, in the form of discriminatory experiences and microaggressions, as well as the proximal level, in the form of internalization of negative stereotypes and expectations for rejection (Meyer, 2003). In order to best target and reduce discrimination of all stigmatized identities, all individuals—and psychologists in particular—need to advocate for legislative enforcement of anti-discrimination public policies as well as promote societal ideals of inclusivity and diversity (Sayce, 2003).

The findings of the current study also suggest that social pain minimization is a public health issue that has relevant implications for mental health at the macro-level. Individuals with stigmatized identities that experience discrimination and social pain minimization could develop feelings of isolation, contributing toward thwarted belongingness and subsequent increased suicidality (O'Keefe et al., 2014; Testa et al., 2017). This is particularly concerning as Black Americans are often judged as needing less social support to cope with pain and distress compared to White Americans (Deska, Kunstman, Bernstein, et al., 2020). This lack of social support could contribute toward further mental and physical health disparities in individuals with stigmatized identities. Indeed, the findings of this study provide rationale for expansion of social support initiatives for stigmatized individuals. Social support and anti-discrimination efforts could mitigate the impact of discrimination on health outcomes.

Our findings also have clinical implications regarding bodily mistrust and its relation to suicidality. Treatments targeting interoceptive awareness, and bodily trust more specifically, may be effective in reducing suicidal ideation. For instance, interoceptive awareness interventions designed to strengthen the mind–body connection, such as Mindful Awareness in Body-Oriented Therapy

(MABT) have recently been found to be effective in improving emotion regulation and identifying, accessing, and appraising internal bodily cues (Price et al., 2019; Price & Hooven, 2018). MABT and other mindfulness-based clinical interventions may be useful in the treatment of suicidality through the improvement of interoceptive awareness. Interventions designed to improve interoceptive awareness, such as those incorporating mindfulness, may help break up the connection between discriminatory experiences and suicidality (Lyons, 2016; Price et al., 2019; Shallcross & Spruill, 2018), by helping individuals continue trusting and responding to their bodily sensations even when their internal experiences are invalidated by others. Moreover, treatments that involve accepting the purpose of unpleasant and negative sensations such as acceptance and commitment therapy (ACT) may be useful in treating and preventing suicidal ideation (Hayes et al., 1999).

Additionally, given that part of this increased risk for suicide may be attributed to invalidation experienced through social pain minimization, therapeutic interventions incorporating validation techniques may be promising. Acceptance from family members is a protective factor for suicide in individuals with stigmatized identities (Beverly & Aasland, 2013), and simulating this acceptance through validation in the therapy room may be helpful in suicide prevention. Indeed, Israel et al. (2008) found that therapists using validating, accepting, and normalizing responses with LGBTQ+ clients saw improved mental health outcomes.

Overall, the study has relevant implications for the assessment and treatment of suicide in individuals with minority identities. Assessing for everyday experiences of discrimination, social pain minimization, and diminished bodily trust may be important for accurate assessment of suicide risk in minority individuals. Novel treatments targeting bodily trust, emotion suppression, and invalidation have the potential to reduce suicidality among these individuals.

Limitations and Future Directions

There are several notable limitations of the current study. The study examined mediators of the relationship between discrimination and suicidal ideation, so the results may not be generalizable to other aspects of suicidality, such as specific suicidal behaviors (i.e. suicide plans, attempts, and self-injury). Moreover, the current study used cross-sectional data, and hence we were unable to test a serial mediation model that would allow us to make predictive inferences or assumptions about these phenomena over time. Additionally, the measure used to assess social pain minimization was developed by the authors, and has not yet been validated, though reliability was high in the current and previous studies (i.e., $\alpha = .93$–$.96$; Benbow et al., under review). The current study also included only Black participants, and hence we are unable to generalize findings to other stigmatized identities.

While accounting for these limitations, we believe there is great potential for future research exploring the relationship between discrimination and suicidality. For example, assessing these relations longitudinally would allow us to make predictive inferences and causal conclusions, providing further support for this model. As the current study only assessed suicidal ideation as an outcome for suicidality, future studies should examine suicidal behaviors such as non-suicidal self-injury and suicide attempts as outcomes. Additionally, it will be important to test this model among members of other racial minority groups, sexual and gender minority individuals, and individuals experiencing weight-based discrimination.

Future studies should also consider examining additional mediators between discrimination and suicidality. For example, it is possible that other aspects of interoceptive awareness, such as self-regulation and emotional awareness, may also be potential mediators between discrimination and increased suicidality. As social pain minimization of discriminatory experiences leads to negative emotions (Benbow et al., under review), stigmatized individuals may not only feel less trust in their bodily sensations, but emotional sensation as well. Future studies should consider emotional awareness as another potential mediator of the relationship between discrimination and suicide in individuals with stigmatized identities.

Conclusion

The current study was the first to explore social pain minimization and bodily trust as mechanisms underlying the relationship between discrimination and suicidality. Overall, our results provided preliminary support for a pathway to suicidal ideation through diminished bodily trust and social pain minimization in individuals who have experienced discrimination. These findings suggest that clinical interventions targeting bodily trust and public health policy initiatives targeting social pain minimization may be useful methods of decreasing suicidal ideation in those that face discriminatory experiences.

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(*Appendix follows*)

Appendix

Social Pain Minimization Scale

The following items ask about your experiences sharing negative social experiences with others. We are interested to know, in general, do others recognize or minimize your pain and distress? When thinking about others, imagine sharing experiences with general groups of people rather than any one specific individual. Generally speaking, what is your experience sharing negative social events with others?

When we mention negative social experiences, we refer to things that are socially painful or psychologically distressing like being excluded, ostracized, derogated, disrespected, and treated unfairly.

Please respond to the items on the scale below.

1	2	3	4	5	6	7
Not at all true for me			Somewhat true for me			Very true for me

1. When I tell others about times I've been treated unfairly, I feel people underestimate my hurt.
2. When sharing negative social experiences with others (e.g., being disrespected, derogated, treated unfairly), people minimize my pain and negative emotions.
3. When I tell people about negative experiences like being excluded or being treated rudely, people don't fully recognize my pain.
4. When I talk about it with others, people underestimate how much being excluded or disrespected hurts my feelings.
5. Others don't fully appreciate how much disrespect and mistreatment hurt my feelings.
6. People minimize my pain when I tell them about negative social experiences I've had.
7. People don't validate my emotions when I tell them about times I've experienced disrespect and unfairness.
8. When I tell them, people don't realize how much being excluded and mistreated hurts my feelings.

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